

DENTAL INSURANCE INFORMATION

Patient's Name: _____

PRIMARY INSURANCE

Subscriber's Name: _____

Subscriber's SS#: _____ Subscriber's DOB: _____

Insurance Alternate I.D. Number (if applicable): _____

Employer's Name: _____

Employer's Address: _____ Phone #: _____

Insurance Company: _____ Group Number: _____

Claim Mailing Address: _____

SECONDARY INSURANCE

Subscriber's Name: _____

Subscriber's SS#: _____ Subscriber's DOB: _____

Insurance Alternate I.D. Number (if applicable): _____

Employer's Name: _____

Employer's Address: _____ Phone #: _____

Insurance Company: _____ Group Number: _____

Claim Mailing Address: _____

I have completed the above questions to the best of my ability. If the information is incomplete, I do realize I will pay for my dental visits and submit for reimbursement from my insurance myself. I assume responsibility for fees associated with procedures performed regardless of dental coverage in effect. As a courtesy, Bresler-Richmond Dental Associates will submit charges to my insurance company on my behalf; however, if no payment is received within 60 days, the balance becomes my responsibility. I understand all copays and deductibles are due on the day the service is rendered.

SIGNATURE OF PATIENT OR GUARDIAN IF A MINOR

DATE